

Application for Payment of Health Insurance Premiums

SECTION ONE – CSHCS Identifying Information

1. Name of Client (Last, First MI)	2. CSHCS ID Number	3. Client's Date of Birth (MM/DD/YYYY) / /
4. Does Client have Medicare Part B? <input type="checkbox"/> YES <input type="checkbox"/> NO	5. Does Client have Medicare Part D? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION TWO – Insurance Information

Is this case for:

☐ **COBRA** - Answer questions 6-22

☐ **Insurance Premium (new or continuing coverage)** - Answer questions 11-22

6. Reason COBRA was offered OR may be available	
7. Date of qualifying event / /	8. Date of COBRA notice to employee / /
9. Date COBRA election form was signed (if applicable) / /	10. Has first COBRA payment been made? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list date / /
11. Is insurance coverage through employer? <input type="checkbox"/> YES <input type="checkbox"/> NO	12. Name of employee (if applicable)
13. Name of employer (if applicable)	14. Name of insurance contact person
15. Phone number of insurance contact person ()	16. Name of insurance company
17. Insurance contract number/group number	18. Premium cost per month for client's coverage \$.
19. Date next premium is due / /	20. Date of contract renewal (<i>when rate could change</i>) / /
21. Name and address of company where premium payments are to be sent:	
22. Reason family is unable to pay premium:	

SECTION THREE – Health and Medical Information

23. What is the client's CSHCS covered diagnosis?		
24. What does the health insurance cover:	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> DOCTOR VISITS
	<input type="checkbox"/> VISION	<input type="checkbox"/> DENTAL
25. What are the expected future medical needs for the CSHCS client?		

26. Is it likely the client's insurance will cover these medical needs? Explain.

27. What special health care needs are **not** covered by the client's health insurance?

28. Are there other health insurance coverages for which the client might be eligible (e.g. Medicare Part B, Medicare Part D, other private health insurance, etc)? ☐ YES ☐ NO

Explain:

29. Additional Comments:

Attach the following information:

- Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.
- Copies of Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.
- Copy of the completed COBRA election form if health insurance coverage is to be maintained under the provisions of COBRA.
- Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.

Mail this application and attachments to:

MDCH/CSHCS
Insurance Specialist
320 S. Walnut St., 6th Floor
Lansing, MI 48913

OR

Fax: 517-335-8055

For questions call:

Family Phone Line: 1-800-359-3722 and
ask for the Insurance Specialist

SECTION FOUR – Verification and Signature

- By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.
- I understand that I may need to show proof of this information.
- I understand that the information shared might relate to HIV, ARC, or AIDS if the Client has those conditions.

Signature of Legally Responsible Party or Adult Client

Date Signed

MDCH USE ONLY

<p>MDCH Action</p> <p><input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED</p>	<p>MDCH Signature _____ Date _____</p>
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Copy Distribution:

Client/Family
LHD

AUTHORITY: Title V of the Social Security Act

COMPLETION: Is voluntary, but is required if CSHCS program services are desired.

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